IS MENTAL HEALTH SCREENING NECESSARY AS PART OF THE COMPREHENSIVE HEALTH SCREENING FOR REFUGEES RESETTLED IN MARYLAND?

By

"Ndidi Nwamaka Anude"

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Approved by:

Cheryll D. Lesneski

Faculty Advisor: Cheryll Lesneski, Dr.P.H

Nancy G. Baruch 04/04/08

Content Reader: Nancy Baruch, RN, MBA

ABSTRACT

Refugees are vulnerable populations who have been forced to leave their homes and countries of origin as a result of persecutions, wars, political and civil unrest, etc. and are unable to return back. A significant number of the refugees resettled in the United States are resettled in the state of Maryland. The Federal Refugee Act of 1980 entitles refugees being resettled in the U.S to be screened systematically. This screening, though not mandatory, is intended to ensure that the unique health needs of refugees which may impede successful resettlement are addressed, while protecting public health. In Maryland the refugee health screening provided is geared towards reducing the spread of infectious diseases. Mental health screening is not part of this initial health screening. This paper looks at the policy issues around refugee health screening provided in Maryland. It focuses on the justification for mental health screening to be included as part of the comprehensive screening provided for refugees in Maryland outlining the mental health needs of refugees being resettled. Refugees have been shown to have psychological needs as a result of experiences undergone prior to, during flight and after resettlement. Post traumatic stress disorders, depression, and somatic illness are the mental illness commonly reported in refugees. These psychological problems can affect individual functioning and thus impede their ability to achieve the resettlement goal of financial self-sufficiency in good time.

The benefits of knowing the mental health needs new refugees may have supports including mental health screening as part of the initial general health screenings provided for newly arrived refugees in Maryland. This will provide the refugee health program the

opportunity to link individuals in need of psychological intervention to facilities where they can receive appropriate care early in resettlement.

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List of Abbreviations

CDC- Centers for Disease Control and Prevention

DHMH- Department of Health and Mental Hygiene

HIV- Human Immunodeficiency Virus

INA- Immigration and nationality Act

MONA- Maryland Office for New Americans

ORR- Office of Refugee Resettlement

STD- Sexually Transmitted Diseases

TB- Tuberculosis

UN- United nations

US- United States

USCIS- United States Citizens and immigration Services

VOLAG- Voluntary Agency Organization

WHO- World Health Organization

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Introduction

The United States (US) has been a place of hope for refugees and immigrants from time immemorial. In the past two decades more than two million refugees have resettled in the US. Approximately 70 percent of this total refugee population was resettled in 15 states including Maryland. Between 1986 and 2006, 29,494 refugees, 1.4 percent of this total, were resettled in Maryland (Maryland Office for New Americans, 2007). These refugees come from various parts of the world, mostly developing countries where there have been wars, famine, civil conflict, political instability and the attendant violations of human rights, situations increasingly recognized as public health problems. The unending crises all over the world and the numbers of refugees resettling in the US as a result calls for a continuous re-evaluation of refugees' needs as well as the services being offered to them (Schmitz, Jacobus, Stakeman, Valenzuela, and Sprankel, 2003).

This paper reports the results of my findings while reviewing the Maryland Refugee Health Assessment Protocol (published in 2002), in order to revise and develop a new screening protocol for the state. This assessment took place during my practicum with the Division of Tuberculosis Control, Refugee and Migrant Health of the Maryland Department of Health and Mental Hygiene (DHMH) in the summer of 2007. This paper outlines the Maryland refugee health assessment program as evaluated between June and August 2007. It focuses on the need for mental health screening to be included as part of the comprehensive health screening provided for refugees resettled in Maryland. The increasing awareness of the mental health needs of refugees and its potential in being a barrier towards successful resettlement necessitates refugee health leaders to advocate and promote an agenda towards addressing this health need. Undiagnosed and untreated

psychiatric illness in refugees can also pose a threat to public health. Thus, the individual and public health benefits of mental health screening for refugees will be addressed as the basis for this recommendation.

The primary study question for this paper is**: Is mental health screening necessary as part of the comprehensive health screening for refugees resettled in Maryland?**

Background

Who is a Refugee?

Following the 1951 United Nations (UN) refugee convention, the term refugee is defined as "a person who is outside his or her country of nationality or habitual residence; has a well founded fear of persecution because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail himself or herself of the protection of that country, or to return there, for fear of persecution" (United Nations High Commissioner for Refugees (UNHCR), 2007). This definition of refugee was expanded in 1967 to include those who fled general danger (such as war and violence in their home country) rather than just those who feared persecution because of the special situations previously defined. Examples include the national wars of emancipation and post-independence conflicts in both Africa and Asia which contributed greatly to the problem of mass refugee movements in the early 1960s. Again, in 1984, this definition was further expanded to include victims of massive human rights violations. Given the above definitions, it is important to note that the term "refugee" excludes those who have left their homes solely for the purpose of seeking a more prosperous life.

The Refugee Resettlement in the US

Based on the above definitions, individuals who have been recognized as refugees by the UN and by the international community are entitled to humanitarian assistance and legal benefits in the countries where they are resettled. Due to the constant need for refugee resettlement, the Federal Refugee Act was enacted in 1980 in the US, incorporating into US law the international definition of a refugee contained in the 1951 United Nations Convention Relating to the Status of Refugees and its 1967 Protocol (United States Citizenship and Immigration services (USCIS), n.d). This allowed refugees to be admitted into the US on humanitarian grounds. In addition, the Refugee Act standardized the resettlement services for all refugees admitted to the US resulting in the establishment of the Refugee Resettlement Program, a federally-funded program that provides cash assistance, medical assistance, health screening, and social services to refugees in order to assist with resettlement and to help them to achieve economic self-sufficiency as quickly as possible after arrival in the United States (Office of Refugee Resettlement (ORR), 2007).

Prior to coming to the US, refugees are required by the Immigration and Nationality Act (INA) and the Public Health Service Act, to undergo medical examinations in their country of origin or temporary asylum as part of their visa application process (Centers of Disease Control and Prevention (CDC), 2007). The purpose of the medical examination is to identify the presence of medical conditions that could require follow up or constitute a public health concern. Infectious diseases of public health significance such as Tuberculosis (TB); Hansen's disease (Leprosy); Human Immunodeficiency Virus (HIV) infection and other sexually transmitted diseases

(STDs) such as syphilis, gonorrhea, chancroid, etc; and mental disorders or problems with current drug use result in ineligibility for admission to (or exclusion from) the United States under the provisions of the Immigration and Nationality Act (Centers for Disease Control and Prevention (CDC), 2007). In addition, because refugees often have unmet health needs and/or come from situations of poor hygienic conditions, infectious diseases may be endemic. Thus, US regulations permit and fund (through a federally subsidized refugee resettlement program) a second, domestic screening to be initiated as soon as possible following arrival to the U.S. The aim of this second screening is to help eliminate any health-related barriers to successful resettlement while protecting the health of the public. Thus, all states are required to provide health screening and any necessary referrals for follow-up services to all newly arriving refugees in accordance with the Office of Refugee Resettlement (ORR) *Medical Screening Protocol for Newly Arriving Refugees* (Office of Refugee Resettlement (ORR), 1995). States are notified by the Division of Global Migration and Quarantine of the CDC of the impending arrival and refugees are also instructed to contact the respective health department in their location of resettlement within 90 days of their arrival. However, while this health screening is highly recommended it is not compulsory for the refugee to comply in order to remain in the country. Local health departments notified by state refugee programs of a refugee's arrival will attempt to locate any individual who does not report to them. If the person cannot be found, this information is reported back to the state refugee health program.

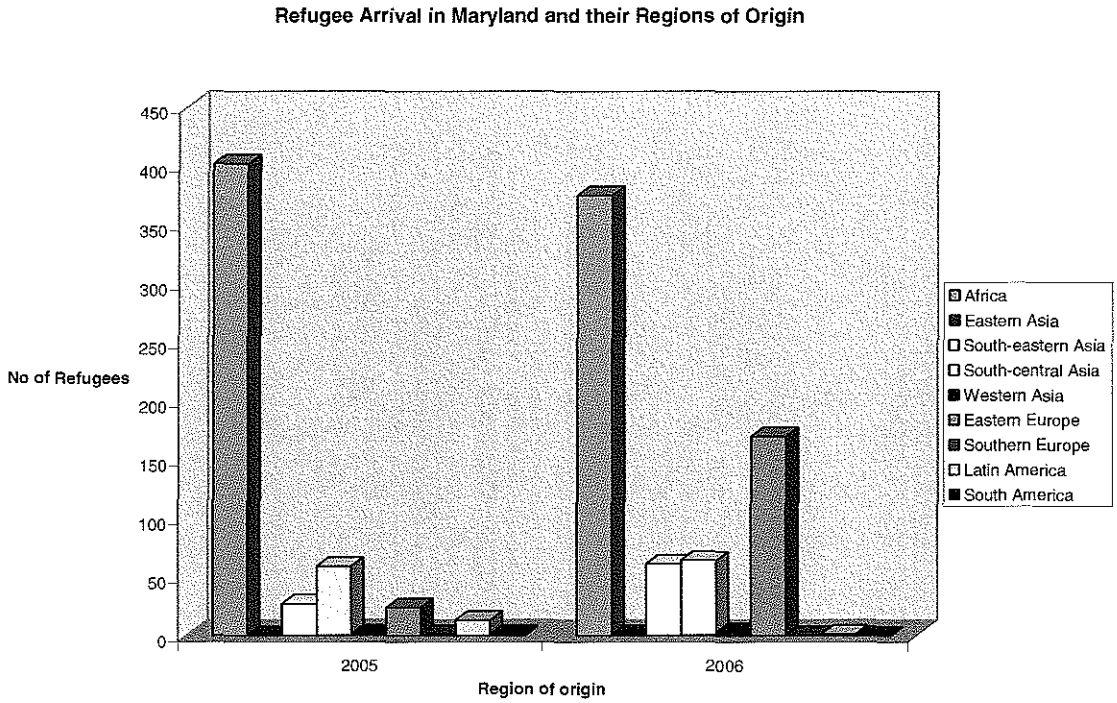
Since the inception of the health screening program, the domestic screening provided for refugees has evolved from being a very limited health assessment focused almost exclusively on TB and STDs to a more comprehensive assessment (Vergara,

Miller, Martin and Cookson, 2003). Yet, basic components of the health screening provided for refugees vary from state to state and from one refugee health program to another, even within a state (Pickwell, 1996 and Vergara et al., 2003)

The Maryland Refugee Health Assessment Program

Although Maryland is not among the top ten states in terms of refugee resettlement, a significant number of refugees do settle there. From 2000-2006, a total of 5884 refugees were resettled in Maryland (Office of Refugee Resettlement, 2007). These refugees arrived mostly from Afghanistan, Burma, Burundi, The Democratic Republic of Congo, Ethiopia, Iran, Liberia, Sierra Leone, Somali, Sudan, and countries that comprise the former USSR and Yugoslavia. Figure 1 shows an overview of refugees resettled in Maryland in 2005 and 2006 using the United Nations defined world regions (United Nations, 2002).

Figure 1: Maryland Refugee arrival and region of origin 2005 and 2006



Source: Author's graphical representation of *Office of Refugee Resettlement data, 2007.*

In response to the Refugee Act of 1980, the Maryland Refugee Health Program of the Department of Health and Mental Hygiene (DHMH) was created to provide for the initiation and oversight of health screening services to refugees being resettled in the state of Maryland. This Program is funded by the Federal Office of Refugee Resettlement (ORR) through the Maryland Office for New Americans (MONA). Funding for the program was initially established to provide reimbursements to local health departments on a fee for service basis with individual "rates" for specific components of the total health screen. However, effective July 2007, reimbursement is now done on one-flat-fee rate per capita, based on an in-depth cost analysis of refugee screening activities.

With approximately 1100- 1200 refugees being resettled in Maryland each year, the Maryland Refugee Health Program stipulates that refugees be provided with an initial health screening within 90 days of their arrival. This screening is provided free of charge by the local health departments in the different jurisdictions of the state, except in Baltimore City, where the refugee health screening service is contracted out by the local health department to a private sector provider, Baltimore Medical Center, a Federally Qualified Health Center (FQHC).

According to the Maryland DHMH Refugee Health Assessment Manual (2002), the purpose of the refugee health screening is as follows;

1. "To verify and ensure follow-up (evaluation, treatment and/or referral) of disease conditions identified during the overseas medical exam and reported on Centers for Disease Control (CDC) forms.
2. To identify, and follow-up persons with communicable disease of potential public importance.
3. To identify and follow-up personal health conditions that adversely impact on effective resettlement (e.g. job placement, language training or attending school)
4. To initiate appropriate immunizations: childhood immunizations and immunizations required for all refugees to become lawful permanent residents of the U.S.
5. To provide orientation to the U.S. health care system, including education about the availability and appropriate utilization of health services" (Maryland DHMH Refugee Health Assessment Manual, 2002, p.1).

Review of Literature

The Mental Health problems of Resettled Refugees

Numerous studies have shown that one of the crucial challenges faced by refugees is the diagnosis and treatment of mental health disorders, yet they are not routinely assessed for this during initial health screening in Maryland or many other states (Williams, 1989; Lipson, 1991). Like Ater (1998) rightly pointed out, nowhere are the healthcare needs of refugees more obvious than in the area of mental health. The mental health issues faced by refugees have been documented since as early as World War II. In fact, many studies have documented a greater prevalence of psychiatric disorders among refugee population than the general US population (Barnes, 2001; Ovitt, Larrison and Nackerud, 2003; Pernice and Brook, 1994; Silove, 1999). Although there is paucity of data on the mental health issues of refugees resettled in Maryland, clinical studies and literature reviews indicate a significant degree of mental distress among refugees resettled in the US and in other countries (Barnes, 2001; Lipson, 1993; Savin et al.; Sabin, Sabin, Kim, Vergara, and Varese, 2006). In Texas, an innovative study was done on newly arrived refugees after a mental health screening component was added to their existing communicable disease screening. The findings from that study revealed a 23.8 percent rate of depression among the refugees screened, a statistically significant higher rate of depression as compared with the US population rate of 5.2 percent (Barnes, 2001). A similar study conducted among refugees resettled in Colorado also supported previous findings that refugees, especially from war-torn countries, experience significant mental health problems early in the resettlement process (Savin, Seymour, Littleford, Bettridge and Giese, 2005).

A study by Ackerman (1997) based on a review of articles on refugee heath studies done from 1981 to 1997 in the MEDLINE files revealed that the most commonly encountered medical problem in refugees were malnutrition, parasitic infestation, hepatitis B infection, dental caries, depression, posttraumatic stress disorder and other related mental health issues. Other investigators report that the most frequent presenting problems among refugees seeking medical care are somatic complaints that defied medical explanation, anxiety, chronic fear, nightmares and sleep disturbances (Arcel, 1995; Barnes, 2001; Frye and D'Avanzo 1994; Westermeyer, 1991). These symptoms were proposed to be the symptoms of the refugees' difficulties with emotional and mental health adjustments during the resettlement process (Barnes, 2001).

Research conducted among refugees in the U.S and elsewhere using standardized mental health screening instruments such as the Hopkins Symptom Checklist and the Harvard Trauma Questionnaire showed post traumatic stress disorders, depression, anxiety and somatization to be common among refugees (Ovit, Larrison and Nackeraud ,2003; Sabin, Sabin, Kim, Vergara and Varese, 2006).

Post Traumatic Stress Disorder

The term post-traumatic stress disorder (PTSD) was adopted by mental health professionals to describe a range of psychological symptoms people may experience following a traumatic event which is outside the normal human experience. The World Health Organization has defined it as: "a delayed or protracted response to a stressful event or situation (either short or long-lasting) of an exceptionally threatening or long-lasting nature, which is likely to cause pervasive distress in almost anyone" (WHO, 2006) For many refugees PTSD follows experiences of torture and/or observation of atrocities

towards others, loss of family members, and a sudden loss of home and country. The symptoms of PTSD include sleep disorders, nightmares, somatic complaints and an exaggerated startle response (Gore and Richards-Reids, 2006). Most people with PTSD frequently re-experience the traumatic incidence in their thoughts usually in nightmares when they sleep and at times during the day. This is called flashbacks. Flashbacks may consist of smells, sounds, image or feelings, and are often triggered by normal events, such as a door slamming, a car firing or seeing a news report. A person having a flashback may believe that the traumatic incident is happening all over again and in the interim lose touch with reality. It is noted that not every traumatized person develops minor or even full blown PTSD (National Institute of Mental Health, 2007). PTSD is to be considered only when symptoms last for more than a month. Usually symptoms begin within 3 months of the traumatizing event, but occasionally will emerge many months or even years afterward. The course of the illness varies. Some people recover within 6 months, while others have symptoms that last much longer becoming chronic. According to the National Institute of Mental Health (NIMH) (2007), people experiencing PTSD often have concurring depression.

Depression

Depression is a serious medical problem that is often debilitating. The severity, frequency and duration of symptoms will differ depending on the individual and his or her particular illness. People with depressive illnesses do not all experience the same symptoms. But signs of this disorder may include persistent sadness, anxiety or "empty" feelings; feelings of hopelessness and/or pessimism; guilt; worthlessness; irritability or restlessness. There may be loss of interest in activities or hobbies once pleasurable,

including sex. An individual may experience extreme fatigue and decreased energy, have difficulty concentrating and remembering details and find it hard to make decisions. Other common symptoms of depression include insomnia, early–morning wakefulness, or excessive sleeping. Appetite changes can include overeating or loss of appetite. Thoughts of suicide or even suicide may occur (National Institute of Mental Health, 2007).

Somatization Disorder

Somatization is a disorder in which there is expression of physical symptoms despite the absence of an underlying medical condition that can fully explain their presence. It often occurs in response to psychosocial stress and generally persists even after the acute stressor has resolved, resulting in the belief that the correct medical diagnosis has not yet been found (Pratt, DeMaso, 2006). People with somatization often present to general medical settings rather than mental health setting which leads to a wrong diagnosis of the associated mental illness, incessant use of health care services and unnecessary medical treatment. Somatization causes significant impairment in functioning and is independently associated with poor health-related quality of life (Prince et al., 2007).

Mental Health Disorders of Refugees in the US

Lipson (1991) in her study on the mental health issues on Afghan refugees resettled in California found that depression, somatization and post traumatic stress disorders were the most common mental problems among Afghans resettled in San Francisco. Since this study was conducted among Afghans living in San Francisco alone, it may not represent the mental status of other Afghan refugees in other parts of

California or the US in general. However, similar mental health problems were also found to be common in studies done among Southeast Asian refugees and other refugee populations with comparatively high levels of physical and mental dysfunction expressed during the first two years of resettlement (Kroll et al., 1989).

Even though research indicates some improvement and individual adaptability three years after resettlement, severe adjustment problems affecting some refugees such as depression, post traumatic stress disorder and somatization still persisted (Ater, 1998 and Lipson, 1993). Moreso, Sack, Green and Seeley (1995), in their study on the mental health of Cambodian refugees resettled in the US, found that the prevalence of psychiatric symptoms was high in this refugee population as well. Infact, even after almost twenty years of being resettled, a study done among the largest Cambodian refugee community in the US revealed a high rate of PTSD (62 percent) and depression (51 percent) in this population (Marshall et al., 2005). Furthermore, a meta-analysis on the prevalence of serious mental disorder in 7000 refugees resettled in western countries revealed that about one in ten adult refugees in western countries experienced post-traumatic stress disorder, about one in 20 had major depression, and about one in 25 had a generalized anxiety disorder, with the probability that these disorders overlapped in many people (Fazel, Wheeler, and Danesh, 2005). About two thirds of data used in this meta-analysis were derived from the US (Fazel et al., 2005).

These mental health conditions demonstrated among refugees are not limited to adults alone. Refugee children and youth were equally found to suffer from similar conditions found in adults, including depression, anxiety and post traumatic stress disorder (Fox, Burns, Popovich, Belknap, and Frank-Stromburg, 2004). Studies

conducted documented that refugee children expose to both violent and non violent trauma exhibit symptoms of post traumatic stress disorder at alarmingly high rates, as high as 75 percent in one community sample (Allwood, Bell-Dolan, and Husain., 2002 and Refugee Trauma Task Force, 2003). These symptoms have been experimentally linked to exposure to trauma prior to migration since these studies were done on children in the midst of war and immediately post war (Allwood et al., 2002; Boothby, 1994; Felsman et al., 1990; Goldstein et al., 1997 and Mollica et al., 1997). Mental disorders in children, if not identified and treated, can significantly impair functioning and academic performance (Mckelvey et al, 2002, Pumariega et al 2005, and Fox et al 2004).

In a research project done with Somali refugee youths resettled in Maryland, most of the children interviewed did not view themselves as having been traumatized, even though they attested to seeing a lot of violence in Somalia and in the refugee camp (Birman, Trickett &Bacchus, 2001). However, a standardized screening tool for mental health was not used in assessing these children so one cannot resolutely conclude that they were unaffected psychologically. Cultural dynamics may have also influenced their response since other studies done among Somali refugees in the US showed that they rarely acknowledged psychiatric problems due to fears of being labeled 'crazy,' difficulties viewing illness within an emotional framework, and the need to address mental health from a physical perspective with a focus on somatic symptoms (Scuglik et al., 2007). This cultural influence is by no means exclusive to Somali refugees.

Psychological stressors

The composite array of emotional and mental health needs demonstrated by many refugees are due to a variety of reasons including persecutions and other traumatic experiences in and while escaping from their countries of origin, difficult camp or transit experiences, and the social and environmental challenges (culture conflict and adjustment problems) in the new host country (Lipson, 1993). The difficult experiences refugees go through prior to, during flight and after being resettled make them extremely vulnerable to mental health problems.

Coelho, Yuan and Ahmed (1980) noted that being forced to uproot and leave home and country can be devastating. It disrupts the stability of a person's selfhood and meaningful relationships to his or her surrounding and often results in reactive psychological disorders. (Lipson, 1993) Threats to personal safety and those of family members, separation and, in many cases, death of family members and friends as a result of civil conflict and political turmoil likewise render many refugees vulnerable to psychological distress. Experiences undergone or witnessed may include actual or threatened physical violence including rape, human rights abuses such as imprisonment without trial, actual or feared persecution and torture. A participant in Lipson's (1993) study on Afghan refugees was quoted as saying:

> "*The communists imprisoned me in 1978; my family did not know where I was. They treated me like hell those eight months, and since then I am not the same. Once I was beaten and left for dead. Another time they beat me on different parts of my body, they electrocuted me in the testicles and under my shoulders. It was like they didn't have hearts in their chest. When I was released I had very bad lower back*

ache and could not sleep. I went to many doctors and took different medications, but nothing worked".

While in-flight the continuum of losses incurred and the devastating conditions such as overcrowding, poor hygiene and under-nutrition experienced also put refugees at risk of developing mental problems. This is particularly true for those who have spent time in refugee camps or detention centres where living conditions are very primitive. The in-flight phase is also usually filled with a lot of uncertainties as the refugees speculate about their fate and that of their loved ones. Wartime and flight provide little opportunity for mental stress/or illness to be addressed or treated since countries of first asylum rarely have the resources to deal with the mental health requirements of a large influxes of refugees. There is often an absence of culturally appropriate means of addressing psychological distress in refugee camps even those that are well established with strong international support and funding (United Nations High Commissioner for Refugees (UNHCR), 2001-2008).

On arrival to the host country and while being resettled, refugees are frequently faced with being separated from close family and friends, a loss of lack of community and associated social networks and concern about the ongoing oppression back home. They have to deal with the complex make-up of the American society including language barriers, cultural differences, sometimes an unwelcoming community expressed as racism and marginalisation by the local host community. The virtual absence of a familiar community network to help them when problems arise in their new country makes many refugees feel very isolated. The economic difficulties many also face upon initial resettlement can compound the situation. Refugees are given a one time lump sum of $890 upon arrival as a form of assistance to help with housing and their basic needs

during resettlement. The expectation is that within nine months, the ORR structured goals of financial self sufficiency, language acquisition, infectious disease control and community orientation will be met. Attaining these goals for many refugee populations can be overwhelming for local programs, especially if significant mental health problems among individual refugees are preventing cooperation with health department and other social agency staff. Several studies suggest that stressors associated with exile may be as significant in terms of contributing to traumatic stress as many events experienced prior to flight (Pernice & Brook, 1996; Gorst-Unsworth & Goldenberg, 1998). Gong-Guy, Cravens, and Patterson (1991) noted that refugees constantly face adjustment difficulties during resettlement which require effective and sustained coping skills that can be made worse by the manifestation of psychiatric symptoms. When these symptoms go unrecognized, successful adaptation and functioning after resettlement is adversely affected (Pumariega, Rothe and Pumariega, 2005).

Methodology

Using search engines such as PubMed and Google scholar, an extensive desk review of published literature on refugees, refugee health screening, the mental health problems of refugees and its impact on refugee resettlement, was carried out. The following key terms "refugees", "mental health disorders", and "refugee health screening" were used in searching databases. In addition, a review of unpublished literature, the Maryland Refugee Health Assessment Policy as well as observations made during my visit to three refugee health clinic sites located in three different jurisdictions within Maryland are also included. Strategies employed in refugee health screening programs in other states and other developed countries were also reviewed for relevance

in terms of context-specific cost-effective and sustainable policy alternatives. Leadership issues and strategies in public health practice in this context were explored.

Results

An assessment of three refugee health clinic sites located in Washington County, Montgomery County and Baltimore city in Maryland was done in June 2007. The assessment revealed that the basic components of the initial health screenings service provided in Maryland varied from county to county. Wide discrepancies existed in the screening procedures and practices of the three clinics visited. In Washington and Montgomery Counties, refugee health screening services were provided by the local health departments while in Baltimore city, screening was contracted out to a private primary care provider, Baltimore Medical Services (BMS). Consequently, the screening services offered by the local health department were provided by nurses while services in Baltimore city were provided by physicians. In addition, TB screening, a routine screening procedure was done optionally based on doctors' discretion in Baltimore city. On the contrary, Montgomery county clinic focused services mainly on TB screening.

This discrepancy in services was assessed to be primarily as a result of the absence of uniform implementation of a standardized state protocol for refugee health assessment. Thus, even though a written protocol was available at the state health department office, it was not in current use at the local level. The absence of a standard operating protocol to guide providers resulted in a lack of understanding of responsibilities, recommended screening practices and program expectations by staff in these clinics. Implementing and maintaining public health programs require leadership to constantly train and empower their workforce while the vision and the mission of the

agency is constantly being shared. Oversight of program activities by leadership is also critical to ensure that program expectations and standards are complied with.

The key components of the routine initial health screening and assessment for newly arrived refugees were;

1. A review of the overseas health examination documentation provided by the refugee
2. Health history and physical examination
3. Basic laboratory testing and medical screening for communicable diseases such as TB (Tuberculin Skin Testing (TST) and Chest X-ray if TST is positive), Hepatitis B, Sexually Transmitted Diseases, and intestinal parasites
4. Immunization review and updates
5. Lead testing for children six years of age and younger

In addition to the above basic assessments, special screening for diseases such as, malaria and dengue fever, etc. may be done if there is a prevalence of such diseases in the country of origin (or departure) as notified by the US Centers for Disease Control (CDC). Also, medical history pointing to such diseases will equally warrant special screening to be done. Associated preventive care treatment and follow-up services to ensure appropriate treatment for TB and sexually transmitted diseases are generally provided by the local health department/clinics. Other health problems detected during screening are referred to appropriate private primary care providers when necessary. This important linkage is sometimes broken, except in Baltimore city where the screening is contracted out to Baltimore Medical Services (BMS), a private primary care provider

ensuring on-site continuity of care and follow-up. Interpreter services and culturally sensitive health education for refugees are also provided during initial health screening.

The "compendium" of health screening services being provided in Maryland and other states are largely geared towards the reduction of the spread of infectious diseases, treating current disease, and promoting preventive health practices for good physical health. While this is very important as "the successful integration of migrant populations into their new communities' health-care systems is critical to the prevention and control of new and reemerging infectious diseases" (Cookson, Waldman et al, 1998), the focus on physical health does not entirely address the health needs of this refugee population. The absence of mental health assessment and appropriate referrals (if needed) may interfere with their resettlement and successful integration into the community.

Is Mental Health Screening Necessary as a Component of the Comprehensive Health Assessment Provided for Refugees?

The numerous pre and post migration stress factors identified during a review of the literature highlights the need to broaden the initial health assessment of refugees in Maryland to include a basic mental health assessment.

According to the landmark Surgeon General's 1999 report on metal health, "mental health is integral to overall health and well-being and should therefore be treated with the same urgency as physical health problems" (US Department of Health and Human Services, 1999). The World Health Organization (WHO) also acknowledges that there is no health without mental health and defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, work productively and fruitfully, and is able to make a

contribution to his or her community" (WHO, 2007). Hence, a screening program centered on infectious disease prevention and control without addressing mental health issues cannot fully accomplish the anticipated goals of:

1. Identifying, in order to follow-up, personal health conditions that can adversely impact effective resettlement (e.g. job placement, language training or attending school); and
2. Facilitating full participation in activities that encourage self sufficiency and successful integration into the larger society.

Since refugees are at risk of mental health issues, public health leaders have to ensure that health promotion and secondary disease prevention is addressed in this population in order to prevent the problem from becoming worse. Mental health is already a serious public health issue in the US. "The United States has the highest prevalence rates (26 percent) of mental illnesses, according to a comparison of 14 developing and developed countries" (JAMA, 2004). Therefore, if refugees are not screened in order to detect mental problems and address them in a timely fashion, they will only add to the numbers. Secondly, as well stated by Barnes (2001) "there are undiagnosed costs to undiagnosed depression" and unquestionably other mental problems. As pointed out earlier, the outlook of many refugees towards mental illness is such that they often validate mental problems with the expression of physical symptoms. As a result there is a tendency to make frequent medical visits to different providers in an attempt to find solutions to somatic complaints resulting in unnecessary costly medical investigations and procedures (Barnes, 2001; Garcia-Peltoniemi, 1991).

Somatic disorder has been shown to be independently associated with poor health-related quality of life and increased health care utilization (Barsky, Orav and Bates, 2005; Gureje Simon, Ustun and Goldberg, 1997). Medically unexplained symptoms such as pain, fatigue, dizziness, etc., which are attributes of most somatic disorders, are the underlying cause of the frequent health care visits (Barsky et al., 2005). Mezey (1960) discovered in his study that the somatic complaints presented by Hungarian refugees were often cultural manifestations of mental distress. Even though depression and anxiety were described as underlying causes of the somatic complaints, they were seldom diagnosed (Mezey, 1960). Individuals with psychological problems may also find it difficult to secure remunerative employment which may cause additional economic burden on society. In the case of those already employed, lost work days and productivity as a result of undiagnosed psychological and mental health problems impose additional economic costs to both the individual and the larger community (Prince et al., 2007)

Aside from the economic burden, mental disorders have been shown to increase the risk for communicable and non-communicable diseases, as well as contributing to unintentional and intentional injury (Prince et al., 2007). Therefore, the early detection and treatment of mental health problems will ensure that refugees are in fairly good health to maximize their potential for meeting the critical and time limited (ORR) goals of employment and self sufficiency (Ovitt, Larrison & Nackerud, 2003).

Even though psychological distress is common among refugees; this does not imply that all refugees should be referred to as having psychological disorders. Not all have been subjected to the same type of stress and individual differences in personality

and coping skills affect responses to stress. Mental health screening with these individuals serves as a good avenue to reinforce positive feelings of adjustment and coping skills, and provide education on available mental health services in the community facilitating entry into mental health care and treatment should it ever be needed in the future.

There have been some global efforts to address the mental health needs of refugees. Attempts have been made in some developed countries that resettle refugees, including Canada, Australia, and the United Kingdom, to provide mental health services for refugees. However, there is paucity of data describing exactly how mental health screening is done in these countries. Literature does indicate that extensive effort are channeled towards providing mental health intervention/services after diagnosis while neglecting the role screening plays in facilitating early entry into treatment.

Here in the US a few states, including Colorado, Texas, Virginia, and Minnesota have included mental health screening as part of their initial health screening for refugees while others like Maryland have yet to do so. The reason for the exclusion of mental health screening for refugees resettled in Maryland is not clear. Since 1995, ORR, Refugee Mental Health Program provides refugee mental health consultation and technical assistance to Federal, State, or local agencies at no cost through an inter agency agreement with priority being given to ORR-funded programs. Although the Maryland Refugee Health Assessment Program is an ORR funded program it is not yet taking advantage of this service since it does not offer mental health screening or services to refugees. The ORR medical screening protocol, from which the Maryland protocol was

derived, noted the mental health needs of refugee population and provided some guidelines on offering mental health assessments to both refugee adults and children.

The nonexistence of a standardized comprehensive national refugee screening protocol that should govern what is done in all the states may be a major contributor to the lack of mental health screening in Maryland. The ORR protocol only serves as a framework that allows for state adaptability and flexibility based on the health needs of the arriving population (ORR protocol, 1995). Some states such as Colorado, California, Ohio, New Jersey, Texas, Virginia and Minnesota have included mental health screening as a component of their screening services even though approaches differ. In Ohio and Wisconsin for example, the screening policy acknowledges the long-term impact of the pre- and migration stressors on effective resettlement on some individuals, but does not encourage mental health screening to be viewed priority for the initial screening encounter. Even so, providers involved in the screening process are encouraged to see the initial screening process as an opportunity to discuss potential psychosocial difficulties refugees may have experienced and to refer refugees with identified mental health concerns to trained experts for evaluation and treatment. Such is also the case in Massachusetts and Minnesota where mental health is assessed as part of the medical history and physical examination done during the initial health screening. Refugees identified as needing further mental health assessment are referred to professional mental health experts. In other states like Colorado, Texas, New Hampshire, and California, extensive mental health assessments are done at the initial screening encounter using standard mental health screening tools. In Colorado, each refugee is screened using tools such as a self-reported check list derived from the Diagnostic and Statistical Manual of

Mental Disorders (DSM-IV), a mental health assessment form, which screens for concerns such as anxiety, depression, and Post-Traumatic Stress Disorder, etc. Based on the result, minor cases are handled in-house (for screening services contracted out to private primary care providers with psychiatry services) while severe cases, especially those due to trauma, are referred to special centers.

Ovitt et al (2003) notes that using standard instruments developed specifically for the task of screening refugees makes the mental health screening process doable, without causing undue stress to the patients. New Hampshire health policy mandates a mental health assessment be addressed in the initial evaluation of refugees. This assessment is usually extensive involving screening for depression, torture, etc. Following assessment, voluntary resettlement agencies (VOLAGS) such as the Interfaith Refugee Resettlement Program work together with refugees, the local health departments and other medical providers in New Hampshire to coordinate and ensure that the mental health needs identified are addressed.

Funding and support for mental health screening in the states that provide it also varies to some extent. In most states funding is usually provided to local programs by the public health department with funding from ORR or Medicaid. Private-public partnerships and private grants also provide funding as is the case with the Colorado refugee health program. In Maryland Medicaid funding is not available for initial refugee health screening, thus other sources of funding to support this additional screening will have to be explored. Mental health screening in Colorado is provided free of charge by the University of Colorado Departments of Family Medicine and Psychiatry and the Colorado Department of Public Health and Environment (Seymour and Hummel, 1999).

In Wisconsin the Mental Health Program is a federally funded program, under which the Bureau of Migrant, Refugee, and Labor Services (BMRLS) receives a grant (from ORR), which it subcontracts to counties, private mental health agencies, and refugee resettlement agencies" to provide mental health screening and mental health services to refugees (Wisconsin Department of Workforce Development, 2007). This program is distinct from the refugee health screening program and is not connected to the general initial health screening done for refugees in Wisconsin.

Policy Options for Mental Health Screening for Maryland

After a review of literature, various mental health screening policies and programs, the following various policy alternatives can be considered for mental health screening for newly arriving refugees in Maryland.

1. Maintain the status quo- Continue with the current practice of no mental health screening for refugees. Maintaining the status quo will curtail program expenditure and time needed for mental health screening to be conducted. Also, additional work will not be added to the already full schedule of the medical providers involved with refugee health screening. On the other hand, the status quo should not be supported since studies have shown that refugees do have mental health needs as a result of their experiences and screening for them is an opportunity to identify those individuals with mental health problems and refer them for appropriate intervention. Mental health was acknowledged by ORR (1995) as an obstacle that can delay refugees' ability to adjust and attain the desired goal of self sustainability. Thus, they recommended that mental health status be evaluated for both adult and children (5-15 years of age) refugees (Office of Refugee Resettlement, 1995). In meeting the

assurance role of public health, leadership should therefore ensure that the appropriate service needed to meet the needs of refugees are available.

2. Routine mental health screening for all refugees as part of the initial health screening- This approach appears to be the gold standard recommended by both mental health professionals and federal agencies concerned with refugee resettlement. The general recommendation is that mental health screening be considered where routine screening is already in place. According to a report by the National Institute of Mental Health on refugee assistance programs, "The broad range of the needs and multiple problems of the refugee population make it essential that mental health service delivery be closely integrated with health and other services" (National Institute of Mental Health, 1985). In other words, mental health screening is best if incorporated into the already existing communicable disease screening, immunization and laboratory testing services. Including mental health screening does not necessarily mean that it will be the focus of the program. Refugees are at high risk for this health problem. Screening them routinely in order to address any mental health problem early in the resettlement process can improve individual functioning, and hence their ability to integrate properly into the society. Then again, including mental health screening to the already existing screening process means an increase in program cost, time and work schedule. A lot of effort will be needed to build the capacity needed to conduct mental health screening among refugees and ensure subsequent follow-up.
3. Mental health screening for selected high risk groups- This is also a good option since not all refugees have been exposed to the same level of trauma and psychological

distress. Moreover, even among those exposed, there are individual responses to experiences, and thus not all may be having negative effects and exhibiting resultant symptoms of mental problems. It is noted this approach may not be as effective as screening all refugees since people who may have major mental health problems can be missed. One cannot accurately predict those who are at high risk solely by their country of origin. As contended by Westermeyer (1985), there are no culturally unique psychiatric disorders as mental health manifestations and distribution varies across cultures. Identifying those in need of help cannot be accurately ascertained without a form of assessment being done routinely during history taking.

4. Optional self-referral mental health screening. This approach requires refugees with mental illness to seek help on their own. This may be problematic because of the noted differences between how various refugees' cultures differ from Western ideas in the way mental distress is communicated. For example, Yamamoto (1978) and Kinsie (1981) noted that Asians also often view mental problem as a source of humiliation and potential ridicule, and thus may not self-refer, similar to the beliefs held by refugees from Somalia. Structural barriers, such as the high cost of health care and/or language may also contribute to poor self-referral since refugees are eligible for medical assistance only for the first eight months after arrival. Most importantly, refugees have been shown to have a tendency of presenting themselves to primary care providers with somatic symptoms. This may lead to underlying psychiatric symptom being overlooked by primary care providers since they are not specialists in mental health.

A ranking of the outlined policy options using a matrix table (see table1) and evaluation based on criteria is shown. Using a scale of 0-5 (5 = very high importance, 4= high importance; 3 = medium importance, 2 = low importance; 1 = very low importance; 0 = not important) each criterion has been weighted based on importance. The criteria of feasibility, impact, cost-effectiveness, political support and individual rights/personal freedom will be used to assess the policy options.

- Feasibility: The assessment of administrative feasibility, operational feasibility, patient acceptability as well as commitment of time and resources needed to implement the policy option. Administrative and operational feasibility is defined here in terms of compatibility with the program's goals, procedures and the availability of personnel needed for implementation of the mental health screening process. In other words, can mental health screening be actually done as part of the initial refugee health screening? How will it be funded? Are there identified funding pathways and levels? Patient acceptability is defined here in terms of its being readily accepted by refugees. This criterion is weighted at 5 because feasibility is crucial to statewide implementation of a mental health screening process.
- Impact: The assessment of effects and outcome of implementing a specific policy option. Does the policy ensure wide coverage, i.e. does the approach cover everybody in need of this service? Usually the possibility of identifying potential mental health problems increases with a wider coverage. Will it be effective in fulfilling the intended goal, i.e. identifying mental health problems in the refugee population? This will also be weighted at 5.

- Cost-effectiveness: The assessment of the costs and benefits of a policy change. How much will including a mental health screening process into the current health screening program cost? How beneficial will mental health screening be in order to address mental health problems early in resettlement? Will the effectiveness outweigh the cost? This is also weighted at 5 as it is critical to analyze the cost-effectiveness of any program alternative before making a definitive choice.
- Political support: This term is defined here as sustained buy-in from relevant stakeholders, technical personnel, funders, and program executives who make the major decisions on allocation of resources and program goals. Legislative support at the state and county level is not critical for this policy as mental health screening is already recommended in the ORR protocol for states to adopt and implement. No policy change at state level can be easy without political support. This is weighted at 3.
- Individual rights / Personal freedom: Assessment of potential individual, group and societal reactions, regarding individual rights and personal freedom, to proposed policy change. This is weighted at 3 because even though legal methods to compel programs to protect individuals and public health may be involved, this is primarily a free service to be offered to refugees with the intent of identifying mental health problems in order to refer them and provide treatment.

Table 1: The Policy Option Analysis and Priority Ranking Matrix

Criteria	weight	Status quo		Routine mental health screening for all refugees		Mental health screening for selected high risk groups		Optional self referral for mental health assessment	
		rating	score	Rating	Score	Rating	Score	Rating	Score
Feasibility	5	++	10	++	10	++	10	±	5
Impact	5	0	0	++	10	±	5	0	0
Cost-effectiveness	5	0	0	++	10	±	5	±	5
Political support	3	±	3	±	3	++	6	++	6
Individual rights / Personal freedom	3	0	0	±	3	++	6	++	6
Total	21	3	**13**	8	**36**	8	**32**	6	**22**
Key: ++ = 2, + = 1, 0 = 0, - = -1, -- = -2									

Source: Constructing a Weighted Matrix, 2006

Recommendations

The two policy options with the highest ratings are routine mental health screening for all refugees or mental health screening for selected high risk groups. Based on a review of the literature on mental health and refugee populations, what other states are currently doing in terms of mental health screening, and the policy option with the prospect of making the most impact, routine mental health screening option is recommended for all refugees in Maryland with the following adaptations:

1. Mental health screening should be offered as part of the already existent general health screening for all refugees being resettled in Maryland. This will ensure that those with psychological symptoms are identified and referred for early and proper

intervention. Mental health screening should be done in a culturally competent manner and with adequately trained interpreters. Leadership should ensure that all providers and resettlement staff are aware of all the cultural factors involved in delivering mental health care to refugees and that mental health information is provided in different languages bearing in mind the cultural norm of the various refugee populations. Education and cultural awareness trainings should be conducted for staff to meet the requirements for refugee health service.

2. Widely used screening tools such as the Hopkins Symptom Checklist (HSCL-25) or the DSM-IV checklist can be adapted and used. The Hopkins Symptom Checklist is recommended by researchers as a good tool to consider because it is quick, easy to understand and already widely tested with and accepted by various refugee populations. Although it has a direct format that avoids use of open-ended questions; it is still able to elicit emotional complaints necessary for basic diagnostic referrals to be made. There are translated versions of this tool already in existence. More information on screening tools for psychiatric care for refugees and how generic screening tools can be adapted for use can be accessed from The Harvard Program in Refugee Trauma website (http://www.hprt-cambridge.org/
3. The Refugee Mental Health Program through its inter-agency agreement with ORR is already providing (at no cost) consultations and technical assistance to other Federal state and local agencies. Since priority is being given to ORR funded programs, the Maryland refugee health assessment program should look into ways of tapping into this already existing service. When implementing programs it is the responsibility of leadership to identify and maximize every resource available to build the capacity

needed to sustain the program. Thus advocacy, consensus and partnership building is required to explore ORR funding and technical assistance to establish a mental health screening component in Maryland

4. Strong public-private partnership development is also recommended as this will help increase funding, program support, advocacy as well as the technical capacity needed for the implementation of this course of action. A good example is the partnership between the Colorado Refugee screening program and the University of Colorado's Departments of Family Medicine and Psychiatry. Apart from private partnerships, the Maryland Refugee Health Program could also look into possible resource sharing from the Mental Health Administration, an organizational division of the Maryland DHMH. When forming partnership, leadership have an important role of helping build a shared vision which is in line with refugee health program.
5. To ensure uniformity, the Maryland refugee health assessment protocol should be standardized across all the clinics providing this service. Standardization should include both general health and mental health assessments. Providers should be trained to carry out mental health screening using an approved screening tool, be aware of and able to recognize symptoms which may require referral for further intervention. They should be aware of where mental health referrals should be made within the community.
6. Community involvement: Refugee health leadership should assess the community, identify and evaluate available resources to determine their usefulness. Refugee and immigrant communities will need to be involved and mobilized. Individuals can be recruited and trained to assist with medical interpreter services since they understand

culture specific mental health contexts. Refugee advocates such as the Advocates for Survivors of Torture and Trauma in Baltimore can also help design recovery programs that are culturally appropriate and sensitive.

7. On going evaluation of the effectiveness of mental health screening and the general health screening based on data collected during screening should be done when program is implemented. Continuous evaluation will help monitor program performance and ensure assessment of the current and potential health needs of the refugee population resettling in Maryland. Refugee health program leadership should use information from data collected to make effective decisions that will help meet the health needs of the refugee population in Maryland.

Conclusion

In conclusion, the refugee health screening provided in Maryland is incomprehensive and inadequate in identifying the health needs which may impede successful refugee resettlement. Refugees are particularly vulnerable to mental health problems and have been shown to have a high prevalence of mental health problems during and after resettlement. The spectrum of mental health and psycho-social disorders experienced by refugees can lead to individual dysfunction, increased health care utilization, increased risk of communicable and non-communicable diseases, and ultimately poor quality of life. These conditions ultimately can challenge the possibility of attaining the critical goal of employment, self-sufficiency and integration into the larger society. Including mental health screening as part of the general health screening is therefore imperative in order to identify and refer refugees with mental health issues for intervention early in the resettlement process.

Based on literature review and ability to make the most impact, routine mental health screening for all refugees is recommended for Maryland. Leading and implementing this change will require time, careful planning, staff training and constant communication between leaders, partners and stakeholders. The role of leadership in implementing a mental health component to the already existing screening program include; planning and analyzing the actions necessary to accomplish this task. Partnership with private and public sectors must be built in order to, increase buy-in, advocacy, funding requirements and expertise needed to sustain this policy. Importantly, the support of all relevant key players, stake holders, funders, technical personnel, etc. must be established through constant communication, education and persuasion. Community mobilization and involvement to help build and strengthen the program is also required. Like every health program, fluctuating funds will be an issue. Innovation will be needed in order to garner the funds required to sustain this venture. Since ORR has provided recommendations for mental health screening and opportunities for funding, consultations, and technical assistance, it is critical that the leadership take advantage of these opportunities when trying to implement this policy.

Lastly, for mental health screening to be effective, leadership must ensure that services provided are of high quality. Constant oversight of activities in the fields should be done to ensure adherence to program goals, requirements and standards. Particular attention should be paid to ensure that the link between screening services and follow-up care is not broken.

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